STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055185	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden City Healthcare Center	1310 West Granger Modesto, CA 95350

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 43943 Based on observation, interview, and record review the facility failed to ensure self-administration of medication was clinically safe and appropriate for one of three residents (Resident 1), when Resident 1 was not assessed for self- administration of his medications prior to being provided his medications to self-administer while out on pass. This failure had the potential to contribute to unsafe medication use by Resident 1 and could have led to Resident 1 experiencing adverse health consequences. Findings: Review of Resident 1 ' s ADMISSION RECORD, indicated Resident 1 was initially admitted to the facility with diagnoses of osteomyelitis (an infection of the bone that causes inflammation and destruction of bone tissue), paraplegia (inability to voluntarily move the lower parts of the body), and chronic pain (persistent pain that lasts for over three months) among other diagnoses. Review of Resident 1 ' s Medication Administration Note, dated 10/17/24, at 3:30 p.m., written by Licensed Nurse (LN) 4, indicated, .Norco [medication used to treat moderate to severe pain, classified as opioid which can slow breathing, cause drowsiness, and be addictive] Oral Tablet .Give 1 tablet by mouth every 4 hours as needed for PAIN .Sent with patient when he went out on pass to school . Review of Resident 1 ' s Medication Administration Note, dated 11/21/24, at 8:00 p.m., written by LN 3, indicated, .Norco Oral Tablet .Give 1 tablet by mouth every 4 hours as needed for PAIN .pt [patient] had taken medication with him while out on pass, pt was given medication by the AM shift [morning shift staff] . Review of Resident 1 ' s Medication Administration Note, dated 2/7/25, at 1:51 p.m., written by LN 1, indicated, .Gabapentin [medication used to treat nerve pain] Oral Capsule .Give 1 capsule by mouth three times a day for neuropathy [nerve pain] .sent with resident out on pass . Review of Resident 1 ' s Medication Administration Note, dated 2/10/25, at 12:55 p.m., written by LN 1, indicated, .Sivextro [antibiotic] Oral Tablet .1 tablet by mouth one time a day for Osteomyelitis of left hip infection Take 1 tablet PO [by mouth] daily sent with resident on pass at 0940am [9:40 a.m.] . (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/13/25, at 10:31 a.m., Resident 1 stated he began taking his medications with him to school in the summer of 2024 and the nurses would put his medication in an envelope to take with him. Resident 1 stated he was no longer prescribed Norco and currently the nurses were giving him Sivextro and gabapentin in an envelope to take with him to school. Resident 1 stated he had not received training from facility staff on how to take his medication while at school. During an interview on 2/13/25, at 1:57 p.m. LN 1 stated she gave Resident 1 his scheduled medications of Sivextro and gabapentin in a baggie to take with him when he leaves the facility to go to school. LN 1 stated she has been giving Resident 1 his medications to take with him to school as long as she has been taking care of him at the facility. LN 1 stated she had not asked administration if it was okay to give medications to a resident prior to going on pass and was not sure if there was a policy regarding it. During an interview on 2/13/25, at 2:44 p.m., LN 2 stated she had seen other nurses give Resident 1 his medication to take with him when he leaves on pass, and she followed their process which included placing his scheduled medications in little baggies. LN 2 stated she had not received training regarding giving Resident 1 his medications to self-administer and she had just copied what the other nurses did. During a concurrent interview and record review on 2/13/25, at 4:20 p.m., with the DON and the ADON, the DON stated she was not aware Resident 1 was going out on pass until last week, or that Resident 1 was taking his scheduled medications with him to self-administer. The DON confirmed there was no Inter-Disciplinary Team (IDT, group of health care professions from different fields who work together to care for a patient) meeting held for Resident 1 to discuss the risk and benefit of him self-administering his medications which would include a measure of his ability to safely self-administer his medications while on pass. The ADON stated the purpose of the IDT meeting was to make sure it was safe for Resident 1 to take his medications out on pass and to discuss with the resident expectations, safe handling, when to take the medications including the timing of the medication administration. The ADON explained this would include teaching the importance of taking his antibiotic on time every day and include the indication for the medication regarding his diagnosis. Through record review the DON confirmed there was no note in Resident 1 ' s chart regarding teachings on safe handling of his medication or self-administration. The DON stated this was important due to possible harm to the resident if they did not take their scheduled medication on time. Review of the facility ' s Policy & Procedure (P&P) titled Self-Administration of Medications, dated 2/2021, indicated, .Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so .As part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assesses each resident ' s cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident .The IDT considers the following factors when determining whether self-administration of medications is safe and appropriate for the resident .The medication is appropriate for self-administration . The resident is able to read and understand medication labels .The resident can follow directions and tell time to know when to take the medication .The resident comprehends the medication ' s purpose, proper dosage, timing, signs of side effects and when to report these to the staff .If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 43943 Based on interview and record review, the facility failed to develop a comprehensive care plan (a plan to address initial goals on admission and physician orders to ensure safety and well-being of a resident) for self-administration of medication for one of three sampled residents (Resident 1) when, Resident 1 was self-administering his multiple medications given to him by facility staff while out on pass from the facility. This failure resulted in a person-centered care plan with individualized interventions not being developed for Resident 1 and had the potential for Resident 1 to not properly self-administer his medications which could have led to subsequent adverse health events. Findings: Review of Resident 1 ' s ADMISSION RECORD, indicated Resident 1 was initially admitted to the facility with diagnoses of osteomyelitis (an infection of the bone that causes inflammation and destruction of bone tissue), paraplegia (inability to voluntarily move the lower parts of the body), and chronic pain (persistent pain that lasts for over three months) among other diagnoses. Review of Resident 1 ' s Medication Administration Note, dated 10/17/24, at 3:30 p.m., written by Licensed Nurse (LN) 4, indicated, .Norco [medication used to treat moderate to severe pain, classified as opioid which can slow breathing, cause drowsiness, and be addictive] Oral Tablet .Give 1 tablet by mouth every 4 hours as needed for PAIN .Sent with patient when he went out on pass to school . Review of Resident 1 ' s Medication Administration Note, dated 11/21/24, at 8:00 p.m., written by LN 3, indicated, .Norco Oral Tablet .Give 1 tablet by mouth every 4 hours as needed for PAIN .pt [patient] had taken medication with him while out on pass, pt was given medication by the AM shift [morning shift staff] . Review of Resident 1 ' s Medication Administration Note, dated 2/7/25, at 1:51p.m., written by LN 1, indicated, .Gabapentin [medication used to treat nerve pain] Oral Capsule .Give 1 capsule by mouth three times a day for neuropathy [nerve pain] .sent with resident out on pass . Review of Resident 1 ' s Medication Administration Note, dated 2/10/25, at 12:55 p.m., written by LN 1, indicated, .Sivextro [antibiotic] Oral Tablet .1 tablet by mouth one time a day for Osteomyelitis of left hip infection Take 1 tablet PO [by mouth] daily sent with resident on pass at 0940am [9:40 a.m.] . During an interview on 2/13/25, at 10:31 a.m., Resident 1 stated he began taking his medications with him to school in the summer of 2024 and the nurses would put his medication in an envelope to take with him. Resident 1 stated he was no longer prescribed Norco and currently the nurses were giving him Sivextro and gabapentin in an envelope to take with him to school. Resident 1 stated he had not received training from facility staff on how to take his medication while at school. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/13/25, at 1:57 p.m. LN 1 stated she gave Resident 1 his scheduled medications of Sivextro and gabapentin in a baggie to take with him when he leaves the facility to go to school. LN 1 stated she has been giving Resident 1 his medications to take with him to school as long as she has been taking care of him at the facility. LN 1 stated she had not asked administration if it was okay to give medications to a resident prior to going on pass and was not sure if there was a policy regarding it. During a concurrent interview and record review on 2/13/25, at 5:07 p.m., the Director of Nursing (DON) stated Resident 1 required a care plan for self-administration of his medications. Through record review of Resident 1 care plans the DON confirmed Resident 1 did not have a care plan for self-administering medications. The DON stated the care plan should have an identified problem, interventions and goals. The DON explained care plans help to teach the patient, and interventions were important for staff and the resident as they provided guidance and would have helped with explaining the risks. The DON further explained the care plan should have been developed prior to Resident 1 self-administering his medications while on pass Review of Policy & Procedure (P & P) titled Self-Administration of Medications, dated 2/2021, indicated, . Residents have the right to self-administer medications if the interdisciplinary team [IDT - a group of health care professions from different fields who work together to care for a patient] has determined that it is clinically appropriate and safe for the resident to do so . Review of P & P titled Care Plans, Comprehensive Person-Centered, revised 3/2022, indicated, . A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident ' s physical, psychosocial and functional needs is developed and implemented for each resident . The interdisciplinary team (IDT), in conjunction with the resident .develops and implements a comprehensive, person-centered care plan for each resident .The comprehensive, person-centered care plan .includes measurable objectives and timeframes .describes the services that are to be furnished to attain or maintain the resident ' s highest practicable physical, mental, and psychosocial well-being, including .builds on the resident ' s strengths .reflects currently recognized standards of practice for problem areas and conditions .Assessments of residents are ongoing and care plans are revised as information about the residents and the residents ' conditions change .The interdisciplinary team reviews and updates the care plan .